HIPAA Privacy Authorization Form
Hampton City Schools
1 Franklin Street
Hampton, Virginia 23669

HIPAA-Compliant Authorization for Release and/or Exchange of Information

Student Name:	Date of Birth:

I hereby authorize
(List name of service provider—Doctor, Hospital, etc. or School)

Provider Address:	
Provider Phone:	Provider Fax:

INITIAL appropriate line(s) for release and/or exchange of information.
_____ To release the following information about my child's treatment and records.
_____ To exchange the following information about my child's education records.

Check information below to be released or exchanged as initialed above:

- ☐ Acknowledge admission/diagnosis
- ☐ Admission intake assessment
- ☐ Social history/psychosocial assessment
- ☐ Psychiatric neurological consultation
- ☐ Educational records
- ☐ Medical information
- ☐ Medication
- ☐ Client records
- ☐ Individual Education Plan/Progress Monitoring
- ☐ Psychological/Neuropsychological Evaluation
- ☐ Vocational Assessment/Information
- ☐ Discharge summary
- ☐ Aftercare recommendations
- ☐ Other:

For the following purpose(s):

This authorization is valid for one year. It will expire on_____. I understand that I may revoke this authorization at any time by submitting written notice of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act (FERPA). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Parent/Guardian Signature:	Date:
Signature of Student (if applicable):	Date:
Send records to the attention of:	